Washington State Department of Social & Health Services

WORKFIRST - PUBLIC HEALTH
CHILDREN WITH SEPCIAL NEEDS INITIATIVE

PUBLIC HEALTH NURSE (PHN) EVALUATION/RECOMMENDATIONS

DATE OF EVALUATION

☐ Initial ☐ Re-evaluation

PARENT/GUARDIAN'S NAME	JAS IDENTIFICATION NUMBER
CHILD'S NAME	CHILD'S BIRTHDATE
HEALTH CONDITION/PRIMARY DIAGNOSIS	
ADDITIONAL DIAGNOSES/HEALTH CONCERNS	
PRIMARY CARE PROVIDER'S NAME (PHYSICIAN/NURSE PRACTITIONER)	TELEPHONE NUMBER (WITH AREA CODE)

EVALUATION COMPLETED ☐ Yes ☐ No

IF NO, REASON ☐ Client refused ☐ Client not home ☐ Other:

I. SUMMARIZE CHILD'S CARE REQUIREMENTS THAT INTERFERE WITH PARENT'S ABILITY TO WORK AND AMOUNT OF TIME NEEDED

CARE REQUIREMENT	FREQUENCY	TOTAL TIME PER WEEK
Appointments:		
☐ Mental Health		
☐ Primary Care Provider		
☐ Dental/Orthodontia		
☐ Specialty Care Provider		
☐ Other Appointments: _____		
Therapies:		
☐ Occupational Therapy		
☐ Speech/Language		
☐ Physical Therapy		
Activities of Daily Living:		
☐ Assistance with activities of daily living		
☐ Monitoring due to behavior needs		
☐ Monitoring due to physical needs		
☐ Monitoring due to medical needs		
Other Care Related Activities/Issues:		
☐ Compromised physical/immune system		
☐ Hospital		
☐ School		
☐ Transportation		
☐ Other: _____		

☐ Short term ..... Care needs are expected to become less ..... Approximate duration: _____

☐ Stable/chronic ..... Care needs are expected to remain about the same ..... Approximate duration: _____

☐ Variable ..... Care needs are expected to vary ..... Approximate duration: _____

☐ Deteriorating ..... Care needs are expected to increase ..... Approximate duration: _____

It appears that the parent:

☐ can work. ☐ can work with limitations. ☐ can't work due to lack of services. ☐ can't work due to child's special needs.
☐ can't work due to parent's condition (development, physical, mental).
☐ Other:

II. RECOMMENDATIONS

Suggestions about services and supports that need to be in place to assist the parent in being able to seek and maintain employment:

III. SUMMARY OFHOME VISIT

Describe special care needs, including any assistance and/or equipment needed, environmental modifications, mobility, feeding (include special food preparation), sleep issues, respiratory, toileting/personal hygiene, medications (dose, frequency, route), behavior issues and management techniques, risk for difficult or violent behavior, transportation issues, and other care related needs, including type and frequency of medical, therapy, and other appointments and times parent needs to be directly available.

Parent's or other family issues (i.e., mental health, domestic violence, substance abuse, pregnancy, other children in family):

IV. SCHOOL

IF YES, NAME OF SCHOOL:

TELEPHONE NUMBER (WITH AREA CODE):

IF YES, FREQUENCY:

Are the child's parents called frequently to school due to the child's condition: ☐ Yes ☐ No

Describe usual follow-up calls from school.

Number of schools days missed this year _____; missed last year _____ (as reported by parent)

Has the child ever been in a successful child care situation? ☐ Yes ☐ No Please explain:

V. OTHER SERVICES CURRENTLY IN PLACE

☐ Division of Developmental Disabilities ☐ Supplemental Security Income (SSI) ☐ Known to PHN: ☐ Yes ☐ No
☐ Family Resource Coordinator (FRC) ☐ Women, Infants, Children (WIC)
☐ Other (specify):

OTHER SERVICES REFERRED TO:

☐ Housing ☐ Education services ☐ Child care ☐ Health services ☐ WIC ☐ DDD
☐ Early intervention ☐ Legal ☐ Mental Health ☐ SSI ☐ Parent support
☐ Other (please list):

REEVALUATION RECOMMENDED IF YES, REEVALUATE IN:

☐ Yes ☐ No ☐ Three months ☐ Six months ☐ Nine months ☐ Other:

PUBLIC HEALTH NURSE'S SIGNATURE	DATE	TELEPHONE NUMBER (WITH AREA CODE)
PRINT PUBLIC HEALTH NURSE'S NAME	COUNTY	FAX NUMBER (WITH AREA CODE)

INSTRUCTIONS FOR COMPLETING THE
PUBLIC HEALTH NURSE (PHN) SUMMARY AND RECOMMENDATIONS

The primary purpose of the PHN evaluation is to document **the impact of the child's (or children's) special needs on the ability of the parent to participate in WorkFirst activities.** The purpose is not to document in a comprehensive nursing evaluation every aspect of the child's special needs - except as they relate to the primary purpose, or to define whether the child can be in a safe and appropriate child care setting.

The purpose of this form is to provide the necessary information to WorkFirst staff in a clear and concise manner. **Explain medical diagnoses, treatments, and care needs in non-medical terminology as much as possible. Please avoid medical acronyms and abbreviations**.

Enter date of the evaluation.

Check whether this evaluation is an initial evaluation or re-evaluation.

Complete the parent/guardian's name and JAS number. Enter the child's name and birthdate.

Complete the health condition/primary diagnosis: This may be a presumed diagnosis, even if you do not have medical records to verify.

Complete the additional health condition/primary diagnosis: This may be a presumed diagnosis, even if you do not have medical records to verify

Complete primary care provider's name and phone number

Complete whether the evaluation was completed or not. If not completed, mark the reason. Document your attempts to contact in Section II. Recommendations section of the form. Include the dates and methods of contact.

I. Summary of Child's Care Requirements

Complete only the appropriate sections. Summarize the amount of time that the client must be available to care for the child. **Frequency** should be entered in time per day, week, month (use abbreviation of da for day, wk for week, and mo for month). **Total Time** should be entered in hours (use abbreviation of hr for hour and hrs for hours). This should be an estimate average total time that the parent must be available to provide care for the child.

Prognosis: If this question is not easily answered, elaborate in the Care Requirements section. You may enter unknown or unsure if you don't have a good idea of the duration of time that the care needs will be needed.

Parent's ability to work: Indicate from your evaluation whether the parent could or could not work due to the child's condition. Document the reason in the "recommendations" section.

II. Recommendations

Document the recommendation of the services or resources that need to be available to parent before they would be able to participate in WorkFirst activities or employment or why they can't participate. Indicate the limitations to participation.

III. Summary of Home Visit

Summary of evaluation with attention to issues that impact the child's and the parent's daily schedule. Document the home environment and your assessment and interaction with the child. Include results of any assessment that was completed as part of the home visit.

Medical Issues: Indicate information about child's medical needs. Include medication, tube feedings, any treatments that might not be done by a child care provider and times parent must be available for the child's medical or therapy appointments, etc. Provide information on a daily basis if necessary

Behavior Issues: Include information about management techniques (such as reduced stimulation in the environment, structured setting or schedule) and perceived differences in behavior in certain settings.

Transportation Issues: Dependence on Medicaid transportation, public transportation, or others for medical and therapy appointments. Reliability of personal car.

Child Care: If the child has ever been in a successful child care setting, note what made that child care successful. If child care was unsuccessful, note reasons.

Parent's or other family issues: Indicate other family issues that are affecting the child or the parent's ability to participate in WF.

IV. School

Note amount of parent's time required to respond to child's needs while in school. Also, note in this section if the child has a one-to-one attendant or other assistance in school. Include name and telephone number of school nurse. Note the number of school days missed as reported by the parent.

V. Other Services

Check if the child is already known to the PHN, as well as other resources already being used by the family. Note the name and telephone number of the PHN and/or FRC who have worked with the family in the Summary of Home Visit box.

PHN name, signature, telephone number, and fax number. Include area code.

Referred to: Indicate the resources/services that you referred the family. You can document the actual resource/service in the "recommendation" section.

Re-evaluation Recommended: Indicate whether you recommend a PHN re-evaluation and the number of months until the re-evaluation.

The referring WorkFirst Case Manager/Social Worker and the parent get a copy of this form. The report must be returned to the WorkFirst Case Manager or social worker within ten (10) working days of the home visit.